

FILED FEB 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1800

588

BIRTH NO. _____ REG. DIST. NO. 182 PRIMARY REG. DIST. NO. 3682 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY LINN			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY LINN		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LINNEUS, RURAL			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BROOKFIELD		
d. FULL NAME OF HOSPITAL OR INSTITUTION LINN Co. REST HOME 4			d. STREET ADDRESS (If rural, give location) RFD #3, 8 MI. N.E.		
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) c. (Last) McCOLLUM			4. DATE OF DEATH (Month) (Day) (Year) JAN. 22, 1949		
5. SEX MO	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 2	8. DATE OF BIRTH OCT. 12, 1863	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) LINN Co, MO	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13a. FATHER'S NAME Wm. McCollum		13b. MOTHER'S MAIDEN NAME SARAH MORRIS		14. NAME OF HUSBAND OR WIFE NANCY C. FINNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. GEO. M. McCollum, Brookfield, MO	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct. (b) Arterio Sclerosis - General (c) 4221 II. OTHER SIGNIFICANT CONDITIONS Senile Cerebral Degeneration			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 0	
22. I hereby certify that I attended the deceased from Jan 12 1949 to Jan 12 1949, that I last saw the deceased alive on Jan 12 1949, and that death occurred at 12 m, from the causes and on the date stated above.					
23a. SIGNATURE Roy R. Haley (Deputy or title) M.D.		23b. ADDRESS Brookfield, MO		23c. DATE SIGNED Jan. 24 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN. 24, 1949		24c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
24d. LOCATION (City, town, or county) Brookfield, MO		24e. FUNERAL DIRECTOR'S SIGNATURE Harold B. Wright		24f. ADDRESS Brookfield, MO	
DATE REC'D BY LOCAL REG. Jan. 22 1949		REGISTRAR'S SIGNATURE BIRDIE L. L. F. 1949		5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

by mail & Webb, (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Harold B. Wright

Signed _____

Student Embalmer

Licensed Embalmer No. *3718*

P. O. Address *Brookfield, Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.